the lease amount varies from one (1) year to the next, the lease amount shall be reclassified to the Operation and Maintenance of Plant cost center.

SECTION 490. CAPITAL LEASES

Leases determined to be Capital Leases under Generally Accepted Accounting Principles (GAAP) shall be accounted for under the provisions of GAAP.

However, all basis limitations applicable to the depreciation and interest expense of purchased assets shall apply to Capital Leases.

SECTION 500. AMORTIZATION OF ORGANIZATION AND START-UP COSTS

Organization and start-up costs as defined in Health Insurance Manual 15 shall be amortized in accordance with the provisions of Health Insurance Manual 15.

SECTION 510. ACCELERATED DEPRECIATION TO ENCOURAGE REFINANCING

A. To encourage facilities to refinance loans for long term debt in existence on December 1, 1992 at lower interest rates and for shorter duration that their current financing, the Kentucky Medicaid Program shall allow an increase in depreciation expense equal to the increased principal payments (principal payments on the allowable portion of the loan under the new financing minus the principal payments under the old financing on the allowable portion of the loan). However, this increase in allowable depreciation expense shall not exceed the reduction in allowable interest expense that results from the refinancing. Interest savings for any period shall be computed as follows: allowable interest expense which would have been incurred under the previous loan, plus allowable amortization of financing costs which would have been incurred under the previous financing arrangement, minus allowable interest expense under the new financing arrangement, minus allowable amortization of loan costs under the new loan (including any unamortized loan expense from the previous loan.) Total depreciation allowed (including the additional depreciation) shall reduce the allowable depreciable basis of the building. Total depreciation expense allowed over the lives of the assets that make up the facility shall not exceed the allowable undepreciated basis of the building. The additional depreciation allowed by the

provision shall first be applied against the allowable basis of the longest lived asset which has any remaining allowable undepreciated basis. The remaining allowable undepreciated basis of the facility at the end of the refinanced loan, shall be depreciated over the remaining useful lives of the assets utilizing straight line depreciation. If subsequent to the refinancing and claiming of accelerated depreciation, the facility is sold (either the operating entity holding the nursing facility licensure or the building on which the accelerated depreciation is claimed) or the facility voluntarily discontinues participation in the Medicaid Program, the following recapture provisions shall be applied:

1. The owner who claimed the accelerated depreciation shall pay the Medicaid Program an amount equal to the difference in depreciation claimed for the certified nursing facility with and without the accelerated depreciation times the average Medicaid percentage of total occupancy in the certified nursing facility.
2. If the facility remains in the Medicaid Program, the allowable depreciable basis for the new owner shall be the allowable depreciable basis had the prior owner never utilized accelerated depreciation for Medicaid reimbursement.

SECTION 520. BAD DEBTS, CHARITY, AND COURTESY ALLOWANCES

A. PRINCIPLE. Bad debts, charity, and courtesy allowances are deductions from revenue and shall not be included in allowable cost.

B. DEFINITIONS.

1. "Bad Debts" means a debt considered to be uncollectible from "accounts receivable" and "notes receivable" that were created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from the rendering of services, and are collectible in money in the relatively near future.
2. "Charity allowances" means an allowance or reduction in charges made by the provider of services because of the indigence or medical indigence of the resident.

3. "Courtesy Allowances" means an allowance that indicates a reduction in charges in the form of an allowance to physicians,

clergy, members of religious orders, and others as approved by the governing body of the facility, for services received from the facility. Employee fringe benefits, such as hospitalization and personnel health program, shall not be considered to be courtesy allowances.

C. NORMAL ACCOUNTING TREATMENT - REDUCTION IN REVENUE. Bad debts, charity, and courtesy allowances represent reductions in revenue. The failure to collect charges for services rendered does not add to the cost of providing the services. These costs have already been incurred in the production of the services.

D. CHARITY ALLOWANCES. Charity allowances have no relationship to recipients of the Medicaid Program and shall not be allowable costs.

SECTION 530. COST OF EDUCATIONAL ACTIVITIES

A. PRINCIPLE. An appropriate part of the net cost of approved educational activities shall be an allowable cost.

B. DEFINITIONS.

1. "Approved Educational Activity" means an educational activity formally organized or planned program of study usually engaged in by providers in order to enhance the quality of resident care in a facility. These activities shall be licensed where required by state law. If license is not required, the facility shall receive approval from the recognized national professional organization for the particular activity.
2. "Net Cost" means the cost of approved educational activities (including stipends of trainees, compensation of teachers, and other costs), less any reimbursements from grants, tuition, and specific donations.
3. "Appropriate Part" means the net cost of the activity apportioned in accordance with the methods set forth in these principles.

C. ORIENTATION AND ON-THE-JOB TRAINING. The costs of "orientation" and "on the job training" shall not be within the scope of this principle but shall be recognized as normal operating costs.

SECTION 540. RESEARCH COSTS

A. PRINCIPLE. Costs incurred for research purposes, over and above usual resident care, shall not be included as allowable costs.

B. APPLICATION. If research is conducted in conjunction with and as part of the care of residents, the costs of usual resident care shall be allowable to the extent that costs are not met by funds provided for the research. Under this principle, studies, analyses, surveys, and related activities to serve the facilities administrative and program needs shall not be excluded as allowable costs.

SECTION 550. GRANTS, GIFTS, AND INCOME FROM ENDOWMENTS

A. PRINCIPLE. Unrestricted grants, gifts, and income from endowments shall not be deducted from operating costs in computing reimbursable cost. Grants, gifts, or endowment income designated by a donor for paying specific operating costs shall be deducted from the particular operating cost or group of costs.

B. DEFINITIONS.

1. "Unrestricted Grants, Gifts and Income From Endowments" means grants, gifts, and income from endowments, funds, cash or otherwise, given to a facility without restriction by the donor as to their use.
2. "Designated or Restricted Grants, Gifts, and Income from Endowments" means grants, gifts, and income from endowments, funds, cash or otherwise, which shall be used only for the specific purpose designated by the donor. This does not refer to unrestricted grants, gifts, or income from endowments that have been restricted for a specific purpose by the facility.

SECTION 560. VALUE OF SERVICES OF NONPAID WORKERS

A. PRINCIPLE. The value of services performed on a regularly scheduled basis by persons (in positions customarily held by full-time employees) as non-paid workers under arrangements without direct remuneration from the provider shall be allowed as an operating expense for the determination of allowable cost subject to limitations contained in paragraph (B) of this section. The amounts allowed shall not exceed those

paid others for similar work. Amounts shall be identifiable in the records of the facilities as a legal obligation for operating expense. Non-paid workers hired under arrangements with a Cabinet for Health Services authorized work experience program shall qualify for the purposes of the principles in this section.

B. LIMITATIONS - SERVICES OF NON-PAID WORKERS. The service shall be performed on a regular, scheduled basis in positions customarily held by full-time employees and necessary to enable the provider to carry out the functions of normal resident care and operation of the facility. The value of services of a type for which facilities generally do not remunerate individuals performing those services shall not be allowed as a reimbursable cost under the Medicaid Program. For example, donated services of individuals in distributing books and magazines to residents, or in serving in a facility canteen or cafeteria or in a facility gift shop shall not be reimbursed.

C. APPLICATION. The following illustrates how a facility shall determine an amount to be allowed under this principle: The prevailing salary for a lay nurse is $5,000 for the year. The lay nurse receives no maintenance or special perquisites. A nun working as a nurse engaged in the same activities in the same facility receives maintenance and special perquisites which cost the facility $2,000 and are included in the facility's allowable operating costs. The facility may then include in its records and additional $3,000 to bring the value of the services rendered to $5,000. The amount of $3,000 shall be allowed if the facility assumes obligation for the expense under a written agreement with the sisterhood or other religious order covering payment by the facility for the services.

D. APPLICATION

1. Unrestricted funds, cash or otherwise, are generally the property of the provider to be used in any manner its management deems appropriate and shall not be deducted from operating costs. It would be inequitable to require providers to use the unrestricted funds to reduce the payments for care. The use of these funds is generally a means of recovering costs that are not otherwise recoverable. However, any interest earned on these funds shall be subject to the interest offset provisions of this manual.

2. Donor-restricted funds that are designated for paying certain operating expenses shall apply and serve to reduce these costs or groups of costs and benefit all residents who use the services covered by the donation. If costs are not reduced, the facility would secure reimbursement for the same expense twice; it would be reimbursed through the donor-restricted contributions as well as from residents and the Medicaid Program.

SECTION 570. PURCHASE DISCOUNTS AND ALLOWANCES AND REFUNDS OF EXPENSES

A. PRINCIPLE. Discounts and allowances received on purchases of goods or services are reductions of the costs to which they relate. Similarly, refunds of previous expense payments are reductions of the related expense.

B. DEFINITIONS.
1. "Discounts" means general reductions granted for the settlement of debts.
2. "Allowances" means deductions granted for damage, delay shortage, imperfection, or other causes, excluding discounts and returns.
3. "Refunds" means an amount paid back or credits allowed because of over collection.

C. NORMAL ACCOUNTING TREATMENT - REDUCTION OF COSTS. All discounts allowances, and refunds of expenses are reductions in the cost of goods or services purchased and are not income. When they are received in the same accounting period in which the purchases were made or expenses were incurred, they shall be used to reduce the purchases or expenses of that period. However, if they are received in a later accounting period, they shall be used to reduce the comparable purchases or expenses in the period in which they are received.

SECTION 580. COST TO RELATED ORGANIZATIONS

A. PRINCIPLE. Cost applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are included in the allowable cost of the provider and is the cost of the related organization. However, the cost shall not exceed

the price of comparable services, facilities, or supplies that could be purchased elsewhere.

B. DEFINITIONS.

1. "Related to Provider" means that the provider, to a significant extent, is associated or affiliated with, or has control of, or is controlled by the organization furnishing the services, facilities, or supplies.
2. "Common ownership" means a relationship shall be considered to exist when an individual, including husband, wife, father, mother, brothers, sisters, sons, daughters, aunts, uncles, and in-laws, possesses five (5) percent or more of ownership or equity in the facility and the supplying business. A relationship shall also be considered to exist when it can be demonstrated that an individual or individual's control or influence management decisions or operations of the facility and the supplying business.
3. "Control" means if an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or facility.

C. APPLICATION. If the provider obtains items of services, facilities, or supplies from an organization, even though it is a separate legal entity, and the organization is deemed to be a related organization, in effect the items are obtained from itself. Reimbursable cost shall include the cost for these items at the cost to the supplying organization. However, if the price in the open market for comparable services, facilities, or supplies is lower than the cost to the supplier, the allowable cost to the provider shall not exceed the market price. An example would be a corporation building a nursing home and then leasing it to another corporation controlled by the owner.

D. EXCEPTION. An exception is provided to this general principle if the provider demonstrates by convincing evidence to the satisfaction of the Department for Medicaid Services that the supplying organization is a bona fide separate organization; that fifty-one (51) percent of the supplier's business activity of the type carried on with the facility is transacted with persons and organizations other than the facility and its related organizations and there is an open, competitive market for the type of services, facilities, or supplies furnished by the organization; that the services, facilities, or supplies are those which commonly are obtained by facilities such as the provider from other organizations and are not

a basic element of resident care ordinarily furnished directly to residents by facilities; and that the charge to the provider is in line with the charge for services, facilities, or supplies in the open market and not more than the charge made under comparable circumstances to others by the organization for services, facilities, or supplies. In these cases, the charge by the supplier to the facility for services, facilities, or supplies shall be allowable as cost.

SECTION 590. DETERMINATION OF ALLOWABLE COST OF SERVICES, SUPPLIES, AND EQUIPMENT

A. PRINCIPLE. Reimbursement to providers for services, supplies and equipment shall be based on reasonable allowable cost as defined in this section.

B. DETERMINING ALLOWABLE COST. The allowable cost of services, supplies and equipment shall exceed the lowest of:

1. The acquisition of cost the provider;
2. The provider's usual and customary charge to the public;
3. The prevailing charge in the locality as determined by Medicare or the Department for Medicaid Services as applicable; or
4. If the item or service is identified in the Federal Register as one that does not vary significantly in quality from one supplier to another, the lowest charge level as defined in 42 CFR 450.30.

SECTION 600. COST RELATED TO RESIDENT CARE

A. PRINCIPLE. All payments to facilities shall be based on the reasonable cost of covered services and related to the care of recipients. Reasonable cost includes all necessary and proper costs incurred in rendering the services, subject to principles relating to specific items of revenue and cost. However, payments to facilities shall be based on the lesser of the reasonable cost of covered services furnished to Medicaid Program recipients or the customary charges to the general public for such services.

Reasonable cost of any services shall be determined in accordance with the principles of reimbursement establishing the method or methods to be used, and the items to be included. These principles take into account both direct and indirect costs of facilities. The objective is that under the

methods of determining cost, the costs with respect to individuals covered by the Medicaid Program shall not be borne by individuals not so covered, and the costs with respect to individuals not so covered shall not be borne by the Medicaid Program.

SECTION 610. REIMBURSEMENT FOR SERVICES OF PHYSICIANS

A. PRINCIPLE. If the physician bills the Medicaid Program for services provided to the resident directly, such amount is to be approved and paid in accordance with the established practices relating to the physician element of the Medicaid Program. If the physician does not bill the Medicaid Program for services provided to the resident, costs to the facility are recognized as indicated in paragraph (C) of this section.

B. REASONABLE COST. For the purposes of determining reasonable costs of services performed by physicians employed full time or regular part-time, reasonable cost of the services shall not exceed what a prudent and cost-conscious buyer would pay for comparable services by comparable providers.

C. APPLICATION. If the physician is compensated by the facility for medical consultations, etc., on a part-time basis, the amounts paid to the physician, if reasonable, shall be recognized by the Medicaid Program as an allowable cost. Physician services by a part-time facility employee for medically necessary direct resident services shall be paid the physician directly through the physician's element of the Medicaid Program. If the physician is a full-time employee of a nursing facility, all reasonable costs including direct resident services, shall be recognized as routine facility costs and shall not be billed to the Medicaid Program directly by the physician.

SECTION 620. MOTOR VEHICLES

A. Costs associated with motor vehicles that are not owned by the facility, including motor vehicles that are registered or owned by the facility but used primarily by the owner, or family members thereof, shall be excluded as allowable costs.

B. In 1986 Kentucky state law established allowable motor vehicle costs to be $15,000 per vehicle, up to three (3) vehicles, if the vehicle is used for facility business. The allowable amount is adjusted annually for inflation according to the increase in the consumer price index for the most recent twelve-month period. Medically equipped motor vehicles shall be exempt from the limit. The Department may approve costs exceeding the limit on a facility by facility basis upon demonstration by the facility that additional costs are necessary for the operation of the facility.

SECTION 630. COMPENSATION OF OWNERS

A. PRINCIPLE. A reasonable allowance of compensation for services of owners is an allowable cost, provided the services are actually performed and are a necessary function.

B. DEFINITIONS

1. "Reasonableness" requires the compensation allowance:

   a. Be an amount as would ordinarily be paid for comparable services by comparable facilities;
   b. Depend upon the facts and circumstances of each case; and,
   b. Be pertinent to the operation and sound conduct of the facility.

2. "Necessary" requires had the owner not rendered the services, the facility would have had to employ another person to perform the services.

3. "Owner" means as any person or related family member (as specified below) with a cumulative ownership interest of five (5) percent or more. Members of the immediate family of an owner, include husband, wife, father, mother, brothers, sisters, sons, daughters, aunts, uncles, and in-laws and shall be treated as owners for the purpose of compensation.

4. "Compensation" means the total benefit received by the owner, including but not limited to: salary amounts paid for managerial, administrative, professional and other services; amounts paid by

the facility for the personal benefit of the owner; the cost of assets and services received from the facility and deferred compensation.

C. APPLICATION. The cost of full-time owner-employees may be included as an allowable cost if the compensation is reasonably comparable to compensation for similar positions in the industry, but shall not exceed the applicable compensation limit for owner-administrator. The compensation of part-time owner-employees performing managerial type functions shall be allowable to the extent that the compensation does not exceed the percent of time worked times eighty (80) percent of the applicable compensation limits for an owner-administrator.

Full-time owner-administrators and full-time owner-employees who perform non-managerial functions in facilities other than the facility that they are primarily associated shall, for Medicaid purposes, be limited to reasonable compensation of not more than fourteen (14) hours per week in addition to the salary in the facility with which they are primarily associated. To be considered reasonable compensation, the owner shall prove performance of a necessary function and be able to document the time claimed for compensation. If managerial functions are performed in a non-primary facility by the full-time owner-administrator or full-time owner-employee of another facility, the cost of the services shall not be allowed for purposes of the Medicaid Program.

Compensation for services requiring a licensed or certified professional performed on an intermittent basis shall not be considered a part of compensation, nor shall it be limited to the application of the owner-administrator compensation schedule, if the professional services (e.g., legal services) would have necessitated the procurement of another person to perform the services.

D. COMPENSATION LIMITATION. Compensation for an owner-administrator shall be limited based on the total licensed beds of the facility in accordance with the following schedule:

LICENSED BEDS	MAXIMUM COMPENSATION
0-50	$33,500

51-99	$38,500
100 - 149	$43,000
150 - 199	$51,300
200+	$52,600

This schedule shall be in effect for the period from July 1, 1991 through June 30, 1992. The compensation maximum shall be increased on July 1 of each year by the Inflation Factor Index for wages and salaries (Data Resources, Inc.). The Department for Medicaid Services shall utilize the moving average for the coming July 1 - June 30 fiscal year based on the latest inflation data available. The adjusted amounts shall be published annually in a reimbursement letter to all cost-based facility providers. Perquisites routinely provided to all employees and board of director's fees shall not be considered in applying owner's compensation limits

E. OTHER REQUIREMENTS

1. SOLE PROPRIETORSHIPS AND PARTNERSHIPS.
The allowance of compensation for services of sole proprietors and partners shall be the amount determined to be the reasonable value of the services rendered (not to exceed the amount claimed for these services on the annual cost reports submitted by the facility). The allowance shall be an allowable cost regardless of whether there is any actual distribution of profits or other payments to the owner. The operating profit (or loss) of the facility shall not affect the allowance of compensation for the owner's services.

2. CORPORATIONS.
To be included in allowable costs, compensation for services rendered as an employee, officer, or director by a person owning stock in a corporate provider shall be paid (by cash, negotiable instrument, or in-kind) during the cost reporting period in which the compensation is earned or within seventy-five (75) days thereafter. If payment is not made during this time period, the unpaid compensation shall not be included in allowable costs, either in the period earned or in the period when actually paid. For this purpose, an instrument to be negotiable shall be in writing and signed, shall contain an unconditional promise or other to pay a certain sum of money on demand or at a fixed and determinable future time, and shall be payable to order or to bearer.

3. ACCRUED EXPENSES PAYABLE.
To be included in allowable costs, an accrued expense payable to an officer, director, stockholder, organization or other party or parties having control shall be paid (by cash, negotiable instrument, or in-kind) during the cost reporting period in which it has been incurred or within seventy-five (75) days thereafter. If payment is not made during this time period, the unpaid expense shall not be included in allowable costs, either in the period incurred or in the period when actually paid.

4. DEFINITIONS

a. "Control" shall exists if an individual or an organization has the ability, directly or indirectly, to influence, manage or direct the actions or policies of the provider regardless of ownership interest.

b. "Negotiable Instrument" means the negotiable instrument shall be in writing and signed, shall contain an unconditional promise or order to pay a certain sum of money on demand or at a fixed and determinable future time, and shall be payable to order or to bearer.

SECTION 640. OTHER COSTS

A. The cost of maintaining a chapel within the facility shall be allowable providing the cost is reasonable.

B. The cost associated with facility license fees shall be allowed if proper documentation proves that the payment is a fee and not a tax.

C. The costs associated with political contributions and legal fees for unsuccessful lawsuits filed by the provider shall be excluded from allowable cost. Legal fees relating to lawsuits against the Cabinet for Health Services shall only be included as a reimbursable cost in the period in which the suit is settled after a final decision has been made that the lawsuit is successful or when otherwise agreed to by the parties involved or ordered by the court.

D. The costs for travel and associated expenses outside the Commonwealth of Kentucky for purposes of conventions, meetings, assemblies, conferences or any related activities that shall not be allowable costs. However, costs (excluding transportation costs) for training or educational purposes outside the Commonwealth of Kentucky (except for owners or administrators) shall be allowable costs. Meetings per se shall not be considered educational; however, if educational or training components are included, the cost, exclusive of transportation shall be allowable. However, travel and associated expenses outside the Commonwealth of Kentucky shall not be allowable for owners and administrators for any reason.

E. The cost of corporate income tax preparation shall be an allowable cost.

F. Stockholder maintenance or servicing costs, such as preparation of an annual report, fees for filings required by the SEC etc., shall be allowable costs.

G. The cost of the Board of Directors' fees shall be allowable, but shall be limited to five (5) meetings annually for single facility organizations and twelve (12) meetings annually for multiple facility organizations and shall meet a test of reasonableness. Other cost associated with Board of Directors' meetings

in excess of the above limitations on the number of meetings shall also be considered to be unallowable costs.

H. Profits or revenues of the parent organization which are from sources not related to the provision of Cost-Based Facility care shall not be considered as reductions in the cost to the Medicaid Program if the investment funds that generated these profits or revenues were not co-mingled with investment funds of the facility, or have been unco-mingled, if necessary, and the source of the funds can be identified according to generally accepted accounting procedures.

I. Employee leave time, if vested, shall be generally an allowable cost. For leave pay to be vested there shall be no contingencies on the employee's right to demand cash payment for unused leave upon termination of employment. Facilities continue to have the option of accounting for leave on an accrual or cash basis. If a facility wishes to switch its accounting method to the accrual accounting basis, the accumulated carryover from the prior year(s) may be expensed as utilized, in accordance with the facility's personnel rules concerning the taking of leave. Concurrent with the expensing of the carryover, current vacation earned shall be accrued.

J. Costs resulting from anti-union activity shall be disallowed. Costs associated with union activity, unless prohibited by the National Labor Relations Act or unless the costs are unreasonable or unnecessary, shall be allowed.

K. In accordance with KRS 216.560(4), payment of penalties shall not be made from monies used for direct resident care nor shall the payment of penalties be a reimbursable cost under Medicaid.

L. The costs associated with private club memberships shall be excluded from allowable costs.

SECTION 650. ANCILLARY COST

A. Reasonable cost of ancillary services provided as a part of total care are reimbursable, but may be subject to maximum allowable cost limits under Federal regulations.
Ancillary services include:

Physical therapy
Occupational Therapy
Speech Therapy
Laboratory procedures
X-Ray
Oxygen
Respiratory therapy (excluding the routine administration of oxygen)

Appropriate time and cost records of therapy services shall be maintained. All contracted services shall be documented by invoices which clearly delineate charges for the service(s) provided to include the resident who received the service, the date the service was provided, the length of time the service required, and the person providing the service. Supplies and equipment shall be itemized separately from treatment on these invoices.

B. DIRECT ANCILLARY COSTS. The direct ancillary costs of Physical, Occupational, Speech and Respiratory Therapy shall include only costs of equipment used exclusively for the specific therapy services, and the salary costs, excluding fringe benefits, of qualified therapy personnel who perform the service, or persons who perform the service under the on-site supervision of qualified therapy personnel.

Personnel qualified for respiratory therapy direct ancillary cost purposes shall be those qualified individuals either licensed by the Kentucky Board of Respiratory Care or the Kentucky Board of Nursing. This definition applies without regard to whether they are facility or hospital-based, or are an independent contractor.

C. The cost of providing general nursing care, including the routine administration of oxygen, routine suctioning, or for standby services shall not be direct ancillary costs. Acquisition, after December 1, 1979, of therapy equipment with a total value of $1,000 for each asset shall have prior approval by the Department for Medicaid Services in order to be recognized as an allowable cost by the Medicaid Program.

SECTION 660. UNALLOWABLE COSTS

A. COSTS EXCLUDED FROM ALLOWABLE COSTS

1. Ambulance service

2. Private duty nursing
3. Luxury items or services
4. Dental services
5. Noncompetitive agreement costs
6. Cost of meals for other than residents and provider personnel
7. Dry cleaning of the resident's personal clothing
8. Drug costs -
9. An allowance for a return on equity is not reimbursable.

SECTION 670. SCHEDULE OF IMPLEMENTATION

The reimbursement system outlined in this part of the Cost-Based Facility Reimbursement Manual took effect July 1, 1991 rate setting. The reimbursement system in effect as of July 1, 1990 shall remain in effect for Intermediate Care Facilities for the Mentally Retarded and Developmentally Disabled (ICF-MR/DD) through June 30, 1991 with the following exceptions:

A. Effective October 1, 1990, drugs shall no longer be treated as an ancillary for ICF- MR/DD facilities.

B. Drugs shall be billed through the Pharmacy Program. The pharmacist shall bill Medicaid directly and the facility shall no longer act as a conduit for drug billings.

C. Those medical supplies previously billed as drugs that cannot be billed through the Pharmacy Program shall be treated as routine cost for services provided on or after October 1, 1990.

SECTION 680. INTRODUCTION TO THE COST-BASED PAYMENT SYSTEM

This payment system is designed for ICF-MR facilities that are providing services to Medicaid recipients and are to be reimbursed by the Department for Medicaid Services. Effective for costs used in rate setting as of July 1, 1991 except as specified in this manual supplement, policies and procedures as stated in the Department for Medicaid Services. Cost-Based Facilities Reimbursement shall be applicable to ICF-MR/DD facilities.

The intent of this reimbursement system is to recognize the reasonable costs associated with the services and level of care provided by ICF–MR facilities.